Mavenclad (cladribine)

Member and Medication Information (required)		
Member ID:	Member Name:	
DOB:	Weight:	
Medication Name/ Strength:	Dose:	Quantity:
Directions for use:		

Provider Information (required)		
Name:	NPI:	Specialty:
Contact Person:	Office Phone:	Office Fax:

FAX FORM AND RELEVANT DOCUMENTATION INCLUDING: LABORATORY RESULTS, CHART NOTES and/or UPDATED LETTER OF MEDICAL NECESSITY TO 855-828-4992

Criteria for Approval (all of the following criteria must be met):

- ❑ 18 years of age and older.
- ❑ Diagnosis of relapsing-remitting or active secondary progressive multiple sclerosis (MS) Chart Note Page#: _____
- ❑ Patient received and understands explicit verbal and written instruction with specific dosing schedule.
- ❑ Trial and failure of at least two agents in the drug class:

Medication/Dose	Details of Failure	Chart Note Page #

- ❑ Provider attests the patient does not have any of the following **contraindications**:
  - Current malignancy.
  - Pregnant or breastfeeding.
  - HIV infection.
  - Active chronic infections (e.g., hepatitis or tuberculosis).
  - History of hypersensitivity to cladribine.
- ❑ Provider attests the following **boxed warnings** have been discussed with patient:
  - MAVENCLAD may increase the risk of malignancy.
  - MAVENCLAD is contraindicated for use in women and men of reproductive potential who do not plan to use effective contraception because of the risk of fetal harm.

Authorization: Up to 13 months; two (2) treatment courses at least 43 weeks apart.
Re-authorization: none

PROVIDER CERTIFICATION

I hereby certify this treatment is indicated, necessary and meets the guidelines for use.

_____ _____

Prescriber's Signature Date